Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST FORT WORTH
PO BOX 203500
AUSTIN TX 78720-3500

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-4508-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Trauma diagnosis is excluded from per diem reimbursement. Carrier continues to process by allowing per diem instead of trauma reimbursement of 75% of billed charges. Additional payment warranted = $23,305.35."

Amount in Dispute: $28,640.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier received the bill for dos 6/8 – 6/12/07 for $39,650.26. To date a total of $5,435.12 has been paid to the provider. The bill was received 3/18/08 and submitted for reprocessing 3/24/08. A copy of the payment summary screen and new EOR will be submitted upon receipt."

Upon reconsideration the respondent wrote "Following the Nurse Review by which the original Bill was processed along with the eob for the Reconsideration done on 10/26/07. No further monies due."

Response Submitted by: Samantha Jackson, ESIS for Labor Ready, P.O. Box 31143, Tampa, FL 33631

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2007 through June 12, 2007	Inpatient Services	$28,640.47	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective December 31, 2006, 31 TexReg 10314, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.308, effective December 31, 2006, 31 TexReg 10314, sets out the procedures for resolving medical necessity disputes.
3. 28 Texas Administrative Code §133.305, effective December 31, 2006, 31 TexReg 10314, defines the dispute process.
4. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
5. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
7. This request for medical fee dispute resolution was received by the Division on March 10, 2008.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-Payment is included in the allowance for another service/procedure.
   - 42-Charges exceed our fee schedule or maximum allowable amount.
   - 17-Payment adjusted because requested information was not provide or was insufficient/incomplete. Additional informat.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - W3-Additional payment made on appeal/reconsideration.
   - 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Findings

1. The requestor billed revenue code 460 for Spirometry at $707.50. The respondent denied reimbursement for these services based upon EOB denial reason code "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer." The respondent states on the re-evaluation report that "Billing for the incentive Spirometry after the initial set up and instructions would not be indicated, as this is a patient controlled activity which a nurse can supervise."

   The requestor also billed revenue code 270 for medical and surgical supplies at $16,905.00. The respondent denied $6768.95 of these charges based upon EOB denial reason code "50-These are non-covered services because this is not deemed a 'medical necessity' by the payer." The respondent states on the re-evaluation report that "Billing for the implants to include the external fixation (this would be considered part of the implant) appears to be excessive and above TX Workers' Compensation allowances, which is cost + 10% mark up. The facility has declined to submit invoices for the implants, therefore, in-house copies of invoices were used for review."

   The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on March 10, 2008. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 No documentation was submitted to support that the issues of medical necessity have been resolved as of the undersigned date.

   The requestor has failed to support that the services billed under revenue codes 460 for Spriometry at

$707.50, and 270 for medical and surgical supplies at $6768.95 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.00. The Division therefore determines that the remaining inpatient surgical services not identified in number one above shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Trauma diagnosis is excluded from per diem reimbursement. Carrier continues to process by allowing per diem instead of trauma reimbursement of 75% of billed charges. Additional payment warranted = $23,305.35."
   - The requestor did not discuss or explain how it determined that 75% of the amount billed would yield a fair and reasonable reimbursement.
   - The requestor does not discuss or explain how additional payment of $28,640.47 would result in a fair and reasonable reimbursement.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 TexReg 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/28/2011 Date
Signature	Medical Fee Dispute Resolution Manager	9/28/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.